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When are health inequalities unfair?

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Journal: Public Health Ethics

1. Introduction

Some live shorter lives and experience more illness than others. Are such inequalities in health unfair?¹ In the past, theories of justice have often bracketed the question of health. One example is John Rawls' enormously influential theory, which principles of justice were developed against the background assumption that every citizen remains healthy over the course of their life and has a lifespan of normal length – thus, the possibility of illness, disability or premature death is set aside.

Initial attempts at giving an account of justice and health focused almost exclusively on the distribution of health care (e.g. Daniels, 1985). Epidemiological knowledge had not yet been widely recognised within philosophical circles, and thus it was natural to assume that our power to influence health was restricted to the distribution of health care. Furthermore, the scope of justice is by many believed to be limited to the distribution of 'social' goods, whereas health has typically been considered a clear example of a 'fact of nature' – that is, apart from what difference we might make to health through the provision of health care. Thus, on the basis of these assumptions, the distribution of health itself would not be a matter of justice.

However, the question of justice in health has attracted increasing attention from philosophers over the last decade or so, and several accounts of justice in health have been put forward (e.g. Daniels 2008, Segall 2010, Venkatapuram 2011). Two further developments have contributed to changing approaches to health in the context of justice. Firstly, pluralist accounts of justice have emerged that argue against a 'narrow' focus on material resources, and insist on the complex nature of advantage or well-being. Secondly, as epidemiological knowledge has advanced and become more widely disseminated outside the field of epidemiology, it is more generally recognised that health is affected by a wide range of factors, many of which are social. We have more scope to influence health than previously

¹ I adopt a broad conception of health inequality, to include inequalities in either life expectancy, healthy life expectancy, or the prevalence or incidence of disease or injury between individuals or groups.

(often) thought. Especially as the social and material determinants of health – for example, living and working conditions and the distribution of income – have received more attention, health can no longer be seen as a pure ‘natural’ good. The distribution of health, and not just health care, is now much more plausibly a matter of justice than it was previously thought to be. While the distribution of health care is still very much a concern, there is a recognition that the distribution of health care does not exhaust questions about distributive justice and health.

However, different views are possible regarding the place health should have in a theory of justice. On the one hand, there is the common intuition that there is something special about health, and that health inequalities are morally worse than other kinds of inequalities. But on the other hand, it still remains the case that the extent to which we can influence health will always be limited. Furthermore, health needs may be very costly for society.

In this paper, I consider how justice in health is related to distributive justice more generally. In particular, do we need a separate account of justice in health, or is justice in health contingent, in some way, on the distribution of other social goods? I will argue that there are two important constraints on the kind of place health should have in a theory of justice, which in turn narrows the scope of the kinds of health inequalities that can be considered unfair. Firstly, health inequalities are mainly of concern when they are correlated with inequalities in other significant social resources. Secondly, inequalities that are caused by human agents or social processes are the proper focus of (egalitarian) justice. Inequalities with natural causes can also fall within the scope of justice where these inequalities are amenable to social intervention, but our response is to a greater extent justifiably contingent on the costs of such intervention.

2. Health and justice

The question about how health should be incorporated in a theory of justice is motivated by two separate concerns. The first is the common intuition that there is something special about health. In the words of Rene Descartes, ‘[t]he preservation of health is ... without doubt the first good and the foundation of all the other goods of this life’ (1953 [1637]: 168). This sentiment is undoubtedly shared by many. On the face of it, that seems right – after all, surely life is special, and without health there cannot be life. Perhaps for this reason, the fact that some live long and healthy lives while other people’s lives are short or marred by illness, may

strike some as particularly unfair. Perhaps, then, health inequalities are morally worse, in some sense, than inequalities in other goods. Thus, one might think that health should have special status in some way in a theory of justice. The second concern relates to the methodology for measuring health distributions. The distribution of health in a population can be measured across individuals or across groups (Asada 2007).² The individual or univariate measure measures only a single variable, the health outcome or expectation of each individual, and as such gives us a ‘pure’ health distribution. The group or bivariate measure measures health in combination with another group attribute, and shows how health varies in accordance with that attribute. A population can be organised into different groups on the basis of an in principle unlimited number of variables, but in the context of health inequality, groups are often defined in terms of variables such as income, occupation, gender, ethnicity, or geographical location. Each measure contains different kinds of information, and the pattern of inequality shown will vary depending on the measure used. Thus, this methodological choice is of fundamental importance, and it has been much debated (see especially Asada 2007, Gakidou et al 2000, Murray et al 1999, Braveman et al 2001, Braveman et al 2011). Proponents of the bivariate measure see justice in health as interrelated with other dimensions of social justice. Thus, the distribution of health should be measured in such a way that it reflects how health varies relative to the distribution of other justice-relevant goods, which is also likely to direct us towards systematic causes. On the other hand, proponents of the univariate measure claim that health inequalities ‘in themselves’ – that is, as measured in isolation from the distribution of other social factors or goods – potentially have moral relevance.

I will address the question of how our concern for health can be included in a theory of justice by pursuing, in turn, two separate lines of inquiry. Firstly, how should we think about health as a currency of justice within a pluralist framework, and secondly, what is the proper scope of justice.

3. Health as a currency of justice in a pluralist framework

² Asada (2013) has suggested a way of combining group and individual measurements, but until this method has been further developed, we must rely on data generated either by the individual or the group approach.

Health is clearly very important for our life prospects and overall well-being. At the same time, few would be prepared to maintain that health is the only good that matters for justice. Thus, we might reasonably take as our starting point the view that health should feature in a theory of justice as one of several ‘currencies’ of justice within a pluralist framework, where justice concerns the distribution of more than one good (for example, health, income and education). But if you take a pluralist view of justice, the question arises what the relationship is between the different currencies or goods. Pluralism can be understood in different ways. On one type of view, distributive requirements for each of the different currencies are separate from each other, in the sense that a distribution of any one good can be just or unjust, independently of the distribution of the other goods. A different type of view accepts some degree of substitutability between the different currencies, and focuses instead on people’s ‘overall’ achievement, across the different currencies or goods taken together. The underlying thought is that having more of one good can, to some extent, compensate for having less of another, in terms of overall well-being.³ Because it is how people are doing overall that ultimately matters, this version of the pluralist account of justice does not entail very specific distributive prescriptions for each of the relevant goods, or components of well-being, considered in isolation – a just (equal) distribution of overall well-being is compatible with unequal holdings of separate goods. Thus, whether or not the distribution of any one good is just would depend on the distribution of the other justice-relevant goods.⁴

Martha Nussbaum’s (2000, 2006) version of the capability approach is a good example of the first type of view. Nussbaum has set out a list of ten basic capabilities, each of which she considers essential to human flourishing. A shortfall in one capability cannot be adequately compensated for by supplying more of another, she argues – the minimum threshold for each of the capabilities is defined independently of how well the individual is doing for any of the other capabilities.

³ For the purposes of this discussion, ‘well-being’ is understood very broadly, as inclusive of the resources or opportunities for well-being. Well-being is here conceived as equivalent to concepts such as welfare, advantage or life prospects.

⁴ To take this kind of view does not entail that one is reverting to a monist or singular, as opposed to pluralist, view of well-being or the currency of justice, according to which all components of well-being can be reduced to, and compensated or substituted by, one single component (typically money). (Though this view could perhaps be construed as a weaker form of pluralism.) Rather, the view recognises that overall well-being or life prospects are constituted by many different elements, which to some extent – but not completely – can replace each other. But these are complex issues. For a more in depth discussion of pluralism, (in)commensurability and substitution, see Wolff and de-Shalit (2007). See also Walzer (1983) and Miller and Walzer (1995).

Michael Walzer's (1983) idea of 'complex equality' can be seen as an example of the second type of view. According to Walzer, a range of different social goods fell within the scope of distributive justice. He further argued that each good belonged to its own 'sphere' of justice, each governed by its own distributive principle. Walzer believed in equality, but did not favour pursuing equality within each of the different spheres. Instead, he argued that if we could successfully block advantage in one sphere from being (illegitimately) converted to advantage in a different sphere, this 'system' of distribution would result in a state of affairs he termed 'complex equality'. In a society of complex equality, different individuals would be successful in different spheres. Miller (1995: 12) sums up the idea of complex equality as follows: 'It is equality that comes about through many separate inequalities, cancelling or offsetting one another in such a way that no one can be picked out as an all-round winner.'⁵

Each of these versions of pluralism represents different ways in which health could be included in a theory of justice. On the first view, health would constitute a separate sphere of justice, with its own distributive criteria applying specifically to health. This view exemplifies what Fabienne Peter describes as a 'direct approach' to equity in health, where '[t]he goal is to achieve justice with respect to the distribution of health outcomes, independently of, but in parallel with, justice in other spheres, such as income or education.' (2004: 94). The distribution of health, in other words, can be just or unjust, independently of how other justice-relevant goods are distributed. This is the view taken by Segall (2010), who explicitly defends the need for a separate theory of justice in health, as opposed to subsuming justice in health within a general theory, on the grounds that '[m]uch of how well our lives go depends on our health status' (2010: 95). In thus emphasising the centrality of health for our life prospects, Segall's view seems to capture the common sentiment that health is special. Anand (2004) similarly advocates specific distributive requirements for health, on account of health being 'a special good'.

On the second understanding of pluralism, on the other hand, justice in health would be more closely interrelated with justice in each of the relevant goods. The fairness of the distribution of any one component of well-being is generally contingent on the distribution of the other components – thus, the distribution of health, considered in isolation from other goods, is

⁵ However, note that there are different ways in which the idea of the 'cancelling or offsetting' of different inequalities can be interpreted. It could be interpreted as disadvantage in one sphere being compensated for by advantage in a different sphere (which is the kind of view Hausman develops, discussed below). Miller (1995), however, argues that Walzer's view is not about compensation in this manner, but rather about equality of *status*, and that complex equality is a state of affairs which prevents the 'dominance' of one person or group over others.

neither just nor unjust. This type of view has most explicitly been defended by Daniel Hausman (2013, 2007).⁶ Hausman considers the appropriate focus is the distribution of overall well-being or life prospects (advantage), rather than the distribution of each single component of well-being, the appropriate focus of justice. He argues that shortfalls in one domain of well-being, including that of health, can often (though not necessarily⁷) be compensated for by any of the other components of well-being. Where shortfalls in one domain can be partly or fully compensated for by doing better in another domain, being well off or badly off in a single domain does not by itself matter. Inequalities in the distribution of each of these components on their own, including health, are in principle compatible with overall equality – therefore, such inequalities are not in themselves unjust, but only insofar as, and because, they reflect inequalities in overall well-being. The moral significance of health inequalities, on this view, is not that they are inequalities in *health*, as such, but rather, their significance lies in the extent to which they correlate with inequalities in other important goods, such as income.

How a person is doing with respect to wealth or income, in contrast to health, is a much stronger indicator of how well they are doing overall, Hausman argues. Because wealth is fungible, wealth can be used to buy advantage in most of the other domains of well-being. High wealth is reliably correlated with high education, high status, and higher effective liberty. Therefore, knowing a person's income does in fact allow us to say something more about how well that person is likely to be doing overall. But this is not true of health, Hausman argues. Health is not particularly fungible, and thus an advantage in health cannot easily be transformed into advantage in other spheres. Health disadvantage may indicate disadvantage in other spheres, but less reliably than poverty will indicate disadvantage in other spheres. Therefore, generally, inequalities in health do not give us a good indication of potential inequalities in overall well-being.

To illustrate the difference between these two views, consider the implications for what kinds of health inequalities are of concern from the point of view of justice. On the first view, according to which health constitutes a separate sphere of justice, a much broader set of health inequalities are included as potentially unjust. Most significantly, individual (univariate) and

⁶ But see for example the writings of Paula Braveman (e.g. Braveman 2006, or Braveman et al 2011), who is also concerned with 'systematic disadvantage' across several domains of well-being, and Deaton (2002).

⁷ One important exception is very severe health shortfalls, such as very premature death, which Hausman does not consider to be compensable. In such cases, the distribution of health in itself can be taken to reflect the distribution of overall well-being, regardless of how other goods are distributed.

group (bivariate) inequalities in health are equally relevant. Furthermore, a wide range of different group inequalities could potentially be unjust – that is to say, there is in principle no limitation on the kinds of group comparisons that are relevant. In contrast, the overall inequality view limits its concern to a much more limited set of health inequalities. Firstly, it focuses on health inequalities between groups rather than individuals, because only the former measurement contains information about how health correlates with other factors that determine overall well-being. Secondly, the concern with health inequalities between groups is restricted to groups defined in terms of components of overall well-being, such as income or education.⁸ Health inequalities between socio-economic groups will be of particular concern.

These inequalities reflect systematic disadvantage across several components of well-being; those who have the worst health also have the lowest income and material security, the lowest level of education, the worst working conditions, and so on. In contrast, health inequalities between men and women may well be an example of a health inequality that is offset by inequalities in other domains of well-being. Women generally live longer than men, but are often disadvantaged in other ways, in terms of for example lower income and fewer opportunities (but see Tsuchiya and Williams (2005) on this point). To the extent that this is correct, health inequalities between the sexes would not be unfair, according to the second pluralist view. On the first view, however, there is no reason to be less concerned with the health inequalities between men and women than with the inequalities between socio-economic groups.

Which of these views, then, represents the best approach to justice in health? As has already been touched on in the outline of these two views, the answer to that question largely hinges on the perceived importance of health. If health is believed to be a particularly important determinant of our life prospects or overall well-being, that would constitute a rationale for being particularly concerned with the distribution of health and for providing principles of justice that apply specifically to health. Treating health as a separate sphere is one way in which we may award health a special status in a theory of justice. In contrast, if we reject this view of health as special, considering its contribution to our overall life prospects as on par with, and to some extent compensable by, other goods, we should primarily be concerned with health inequalities where they correlate with inequalities in other important goods,

⁸ Other group attributes, such as race or geography, may in some contexts be good indicators of socio-economic status, and would thus similarly reflect inequalities in overall well-being.

because such clustering of inequalities gives a better indication of people's overall life prospects. In the following, I will offer some further arguments in favour of the latter approach.

Broadly speaking, we can think of the value of health for our prospects of living a good life in terms of its importance for immediate well-being, opportunity and longevity. Consider, first, the importance of health for opportunity. Poor health affects our ability to engage in a range of ordinary human activities in various ways. Disease, injury and disability can involve either temporary or permanent functional limitations that restrict the range of activities available to us, from the very basic (e.g. self-care, everyday chores) to more complex plans and projects (e.g. pursuing a career or a hobby). This observation forms the basis for Norman Daniels' view of health as having 'special moral importance' (2008). However, many goods, in particular income and wealth, influence one's share of the opportunity range, not just health. Do we have reason to believe that health is more important for opportunity than income? Of course, in an obvious sense, health is a precondition for life itself, and thereby opportunity. Beyond that, however, it seems difficult to make a principled comparison of the relative importance of health and income for opportunity at a very general level.

Still, we can shed some more light on this issue by considering the case of disability. Arguments from the disability literature show that functional limitations may not necessarily limit our opportunities – in fact, the importance of health for opportunity is not fixed, but allows for a great deal of variability. (see e.g. Wolff 2002, Shakespeare 2006, Barnes 2016). Firstly, functional limitations may be partly or fully overcome by making social structures and arrangements more accommodating. Having a disability has often been treated as a clear case of being 'worse off'. The disadvantage associated with being disabled, moreover, has often been assumed to be a direct result of the biomedical impairment itself (e.g. blindness, paraplegia). However, both of these assumptions have been challenged. Importantly, advocates of the social model of disability have argued that many of the disadvantages associated with disability are socially created. Social arrangements are designed in such a way that they suit the needs and preferences of non-impaired people, whereas people who are in various ways impaired are excluded. Of course, there is a discussion to be had about whether it really is true that any disadvantage associated with disability is *entirely* a product of oppressive social arrangements – this view has certainly been contested (see e.g. Shakespeare 2006). However, we can take on board the more modest point that the relationship between biomedical impairment, on the one hand, and a person's ability to engage in ordinary human

activities, on the other, is not absolute or fixed, but is mediated by various features of our social and material environment. Thus, the social context in which one finds oneself is very important – in a society where social arrangements are accommodating to the needs of those with various impairments, one's opportunities will to a much lesser extent be dependent on one's health status (Allotey et al 2003). The degree to which a particular health state gives rise to disadvantage is also a social matter.

Secondly, activities or opportunities may themselves be substituted: one can engage in different types of activities or opportunities for which a given functional impairment does not matter, or one can find different routes or means for achieving the same goals. This seems true, at least, of opportunities conceived as opportunities for flourishing. Such opportunities comprise many different types of activities, and are therefore more easily substitutable. If functional limitations prevent one from engaging in one activity for enjoyment, there are likely to be many other activities for enjoyment one can engage in without being restricted by one's functional limitations. Thus, as long as one has access to an adequate range of opportunities, any specific opportunity loss associated with reduced health may be much less significant – that is, having access to an adequate range of opportunities may offset any specific opportunity loss due to impaired health. But of course, one's access to an adequate range of opportunities will also depend on many other goods. In contrast, opportunities in the Rawlsian sense, as opportunity for jobs and offices, may be much less substitutable. Employment of course can serve many purposes such as being a source of enjoyment, challenge or self-realisation, but central here is its function as a source of income. Functional limitations may make it difficult to find employment and are at the very least likely to substantially restrict one's options, in particular with regards to highly paid employment opportunities. In this respect, to the extent that a particular shortfall in health impairs one's employability or earning potential, it seems right that health is a key determinant of one's level of opportunity. At the same time, however, health has this fundamental impact on opportunity precisely because it interacts with another important determinant of opportunity, income.

In terms of the contribution of health to opportunity, it seems difficult to make the case for health being special. Even permanent functional limitations do not necessarily reduce one's opportunity range substantially, and the extent to which diminished health will impact on opportunity also depends on other goods. Thus, it seems right that health shortfalls, in this respect, are to some extent compensable.

Health is also important because of its effects on our immediate well-being (i.e. how one feels, as opposed to well-being in the broader sense, as advantage or life prospects). Poor health may involve many different symptoms such as pain, discomfort, nausea, ‘feeling ill’, ‘not feeling oneself’, tiredness or fatigue, anxiety and depression. These feelings or sensations, and pain in particular, may be experienced very directly, and can thereby have an immediate effect on our well-being. Furthermore, phenomenologically, such health sensations are often difficult to ignore or adapt to and may continue to be felt acutely throughout their duration. These health sensations, although far from being the only constituents of well-being, can be so strong that they effectively block other forms of well-being. While other sources of well-being may to some extent compensate for or distract us from pain, for example, the worse the pain is, the less able we will be to appreciate these other sources. To some extent, it is true that being free of such negative health sensations is a precondition for experiencing other forms of well-being, the more so when they are very severe. Thus, perhaps we might say that in this respect health is indeed special – that there is a special importance to being free from debilitating pain, anxiety and depression. At the same time, however, we might be more sceptical that absence of moderate or mild instances of such sensations is special in the same way. Furthermore, it is worth noting that severe or intense health sensations are not unique in this respect. Other emotions, such as grief and fear, can equally prevent us from experiencing other forms of well-being. The case is not that clear-cut, it seems.

Finally, as already remarked upon, health is of course necessary for life itself. In that limited sense, as a precondition for life, loss of health is not compensable. However, beyond that rather obvious observation, we might consider to what extent longevity is compensable by other goods. What is the value of having a long or normal lifespan – or conversely, what is the nature of the disadvantage of living a shorter life? It is not entirely straightforward how we should conceive of the relationship between length of life and overall well-being during life, as the time of one’s death does not in itself affect the quality of one’s life lived up to that point.⁹ But one aspect of the disadvantage of a shorter life seems to be a diminished range of

⁹ With the important exception of cases where the time of death is known in advance, for example if one has been diagnosed with a terminal illness. See Carel (2008) for an in depth and insightful discussion.

opportunities, in terms of amount as well as variety. At the same time, loss of opportunity does not seem to fully capture the nature of the loss – perhaps the loss of opportunity due to premature death is different from the loss of opportunity due to for example functional limitations. Maybe there is a special loss involved in the loss of opportunity to pursue longer-term projects and plans. Perhaps we can say that a very short life represents a unique form of disadvantage, and one that is only to a very limited degree compensable by other goods. On the other hand, as we approach a lifespan of normal length, it seems more plausible to conceive of the contribution of further added life years to overall well-being as compensable by other goods, and the case for attributing special importance to further added life years seems less clear-cut.

While these observations far from exhaust the question of the extent to which health should be considered to have special importance, they underscore its complexity. Health is a multi-faceted good, valuable in different ways, and it is difficult to give an overall verdict concerning its importance and its contribution to our life prospects. Nevertheless, the preceding discussion suggests that it is difficult to give substantial content to the idea that health is special. In general, the importance of health seems comparable to, and to some extent compensable by, that of other components of well-being. While there are some exceptions to this general observation, these are clearest in the case of very severe health shortfalls. But that is likely true of other goods too – at the margins, few goods are substitutable. Thus, on balance, we should consider health as on par with other important components of well-being, and as such, there is no reason to think of health inequalities as in themselves of special concern, or of greater moral relevance than inequalities in other goods. Thus, health inequalities are mostly morally significant insofar as they reflect overall inequalities.

4. The scope of justice and the nature of the causes of health inequality

As noted in the introduction, one important driver behind the growing interest in health among philosophers has been the more widespread recognition that health is not a mere ‘fact of nature’, but is also affected by a range of social and material factors. Nevertheless, while our power to influence health is greater than what was previously recognised in some circles, it remains limited in important ways. Health cannot, of course, be directly distributed, and so

we can only influence health via such factors that affect health. But health is affected by a wide range of factors, some of which are beyond the scope of social control, such as certain biological factors or the effects of chance. Furthermore, health needs could be very costly for society to address. What relevance, if any, does our to some degree limited power to influence health outcomes have for how health should be incorporated in a theory of justice? The answer to this question depends on what view one takes with respect to the scope of justice – the kinds of phenomena to which our principles of justice apply, or what kinds of outcomes or states of affairs can be deemed to be just or unjust. Of course, claims of justice are not the only claims of assistance that have weight; even if a particular outcome is deemed a misfortune rather than an injustice, we might think we ought to do something about this outcome. But where no human agent has caused the suffering, it is not clear where the duty falls. We may often wish to do something to reduce misfortune in these cases too, but our attempts to rectify inequalities that are mere misfortunes rather than injustices will to a greater extent be contingent on the expected costs and benefits. Claims of justice, on the other hand, are typically conceived as having greater weight than other concerns, in the sense that we ought to expend more effort and resources to rectify injustices (Nagel 1997). It is an important question, therefore, how far requirements of justice extend.

I adopt what Nagel (1997) refers to as an expansive deontological conception of justice. Deontological conceptions limit the scope of justice in various ways – in particular, in terms of how the relevant outcomes are produced. A key issue is how far the requirements of justice extend to cover outcomes produced by nature as opposed to social institutions or human agents. On what Nagel calls a consequentialist account, the fact that an inequality has a natural cause has no special significance, in the sense that it does not serve as a reason to limit society's responsibility to rectify that inequality. A deontological account, on the other hand, considers society less accountable for inequalities with natural causes. Still, within a deontological account thus construed, there is room for different degrees of responsibility. A minimalist deontological conception views naturally caused inequalities as a neutral background, a matter of luck or fate; only direct human or social causes can be just or unjust. An expansive conception, on the other hand, includes our responses to naturally caused inequalities amongst the kinds of phenomena that can be just or unjust.

After all, one might argue, it seems somewhat artificial to place such weight on the distinction between natural and social causes. As Nagel points out, '[e]very society is in the business of

transcending the state of nature' (1997: 305). Social mechanisms interact with natural inequalities, such as differences in natural endowment or skills and talents, and as a society we face a choice in the design of our social institutions in terms of how far they should aim to mitigate the effects of such natural differences on people's life prospects or overall well-being. We can think of the issue in the following way. There are two factors that are relevant. Firstly, there is the question of which inequalities we have the power to do something about, regardless of the nature of the cause of these inequalities. Where the cause is social, it is often, but not necessarily, within our power to intervene (for example, it could be too late to do something about it, or perhaps the damage that is done is irreparable); or, we may at least be able to stop producing such inequalities in the future. Conversely, the fact that a cause is natural does not imply that we will be powerless to do something. Health care, of course, is a case in point: while many health conditions have natural causes, health care is a socially created remedy, the allocation of which is within the control of our social institutions. Secondly, there is the question of the costs of intervention, whether the intervention addresses a socially or naturally caused inequality or disadvantage. The upshot is that even if, in principle, socially caused inequalities are held to constitute the primary kind of injustice, it seems that we still ought to address naturally caused inequalities or disadvantages where we can. Thus, society's responses to such outcomes could be considered a matter of justice. However, whether or not a failure to intervene constitutes an injustice ultimately depends on the costs of intervention. It will be a difficult matter to delimit precisely society's responsibility in terms of the level of resources and effort that should be expended, but in general, the less costly the intervention, the more unjust a failure to intervene will be.

Taking this view of the scope of justice has some implications for how health should be incorporated into a theory of justice. First of all, the requirements of distributive justice would then primarily apply to socially controllable factors. Health, however, remains a borderline case, only partly under social control. Thus, on this view, our principles of justice would not apply directly to health, in the sense that they specify when a distribution of health is just or unjust. Rather, we should think of health as subject to these principles in a secondary or derivative sense. That is to say, in the first instance, health inequalities are unjust insofar as they have unjust social causes – such as being the result of an unjust distribution of other important social resources that are directly governed by our principles of justice. We should, however, consider a possible qualification of this overall view. Even if we consider questions about the fair distribution of income and other social goods to be prior to the question of the

fair distribution of health, we should not disregard the possibility of our concern for health playing a more limited role in shaping our principles of justice. Thus, if a distribution of social goods that we would otherwise consider fair – that is, independently of a concern with health – should turn out to result in substantial health inequalities, we should consider amending our principles of justice governing those institutions, with an eye to reducing the inequalities in health. That is, we may allow that the distribution of health, insofar as it is affected by our social and political institutions, should to some extent feature in our assessment of those institutions.¹⁰

There is also a second way in which health will be of concern within an expansive deontological account of justice. On this view, society's responsibility is not strictly limited to outcomes with social causes, even if they are the primary concern for justice, but also extends to such outcomes which, regardless of the nature of the causes, are amenable to social intervention. Thus, health inequalities can be unjust if it is within our power to influence these outcomes, within reasonable limits on costs.

Both of these two ways in which health becomes subject to justice give us reason to be concerned with how the distribution of health varies in relation to the distribution of other social goods, rather than with the distribution of health 'in itself'. If health is not directly governed by our principles of justice, there is no sense in which a distribution of health by itself is just or unjust. On the other hand, bivariate health distributions, which reflect how health correlates with other socially significant factors, will be of concern for justice, because this pattern is likely to reflect systematic social causes which may be unjust, and which, furthermore, are likely within our power to do something about. Furthermore, a systematic correlation between the distribution of health and other social factors may also reflect injustice in a different way, independently of the nature of the causes of poor health or our capacity to address these health outcomes. If poor health correlates with disadvantage in other important goods, this could also be a result of poor health causing disadvantage in these other goods, rather than the other way around. (For example, according to the 'health selection' hypothesis, the socio-economic inequalities in health are a result of poor health causing low income, as opposed to low income causing poor health.) The mechanisms and pathways by which poor health leads to other forms of disadvantage will partly be a product of our broader

¹⁰ In the same vein, Peter suggests that information about the distribution of health could be used to 'supplement economic and sociological information about the achievements of different social arrangements in the basic structure of society' (2004: 103).

social arrangements, and accordingly there will be some scope for us to intervene. For example, if poor health leads to low income by limiting one's ability to work and earn a decent income, this could potentially be an instance of injustice, if we as a society have insufficient sick pay arrangements, or have failed to make work environments and working conditions sufficiently accommodating to the needs of persons with poor health. (Though what would count as 'sufficient' here in order to discharge claims of justice would be contingent on the costs of such arrangements, in accordance with the expansive deontological account of justice as described above.) Thus, correlations between health and other social goods are of concern from the point of view of justice also because they can tell us something about how health interacts with social mechanisms to produce clustering of different inequalities and overall disadvantage.

5. Concluding remarks

In this paper, I have considered what place health should have in a theory of justice. On the basis of two lines of inquiry, I have argued against adopting separate distributive principles for health, and in favour of conceiving justice in health as interrelated with, and contingent on, justice in the distribution of other important social goods and resources, in particular income. Accordingly, health inequalities are unfair when they are the result of an unfair distribution of resources. Firstly, I argued, the importance of health for our overall well-being is generally comparable to that of other components, and thus, we should mostly be concerned with health inequalities where they correlate with inequalities in other important goods. Secondly, on an expansive deontological conception of justice, inequalities that are caused by human agents or social processes are the primary focus of justice. Taking this view of the nature of justice restricts our responsibility to such inequalities that are within the scope of social control. But health is a borderline case, and thus does not fall directly within our principles of justice; rather, we should see fairness in the distribution of health as derivative of, or secondary to, the fair distribution of other important social goods. While reducing health inequality remains an important task, ultimately health inequality is but one aspect of overall inequality.¹¹

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